Medicaid



Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Hospital Bed	
Section A	
Patient Name, Address, Telephone Number, and Date of Birth	Physician Name, Address, and Telephone Number
Medicaid ID Number	NPI Number
Residence	
Diagnosis	Estimated Length of Need (Months) 1–99 (99=Lifetime)
Prognosis	
Date of Last Evaluation by a Physician	Physician's Name
1. Has the patient received a trial in the use of this item?	☐ Yes ☐ No
2. Does the patient have the physical and mental ability to operate or use the item?	
3. Can the patient or caregiver be responsible for the maintenance of this device?	
4. Does the patient require positioning of the body in ways not feasible with an ordinary bed? Yes No	
5. Is elevation of the head at more than 30 degrees required due to \square congestive heart failure \square chronic pulmonary disease \square aspiration?	
6. Does the patient require traction which can only be attached to a hospital bed?	
7. Does the patient require a bed height different than a fixed height bed?	
8. Does the patient require frequent changes in body position and/or have an immediate need for change in body position? Yes No	
9. Is the patient Room Confined Bed Confined	
□ Non-Ambulatory □ Ambulation Impaired □ Other	
10. Narrative description of all items, accessories, sizes and options, etc., including model numbers . If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document). Yes, additional attachments are included. No, additional attachments are not included.	
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability. Signature and date stamps are not acceptable.	
Dhysisian's Signature	Data (mm/dd/mm)
Physician's Signature	Date (mm/dd/yyyy)